# DEPARTMENT OF NATURAL RESOURCES
# WORK RELATED INJURY/ILLNESS REPORT FORM
**(Use this form to document a work related injury or illness.)**

**Injured employee:** _____
*Last Name* *First Name* *Middle Name or Initial*

**Employee Identification Number (EIN) or Social Security Number:** _____

**Resident mailing address:** _____
*Street* *City* *State* *Zip*

**Home or Cell phone:** _____ **Work phone:** _____ **Sex:** Male ___ Female ___

**Date of birth:** _____ /_____ /_____ **Marital status:** Unmarried ___ Married ___ **Hire Date:** _____
*mm dd yyyy*

**Job (Position) title:** _____

**Work Location:** _____

**Employment status:** Full Time ___ Part Time ___ Temporary ___ Permanent ___ **Number of dependents:** _____

**Hourly wage rate (at time of incident):** $_____ **Number of days worked per week:** _____

**Did you receive full pay for the day of injury?** Yes___ No ___ **Did your salary continue after incident?** Yes___ No___

**Time you began work the day of the incident:** ____:____ a.m. ___ p.m. ___

**Date of injury/illness exposure:** _____ / _____ / _____ **Time of injury/illness exposure:** ____:____ a.m. ___ p.m. ___
*mm dd yyyy*

**Date employer was notified:** _____ / _____ / _____ **Date disability began:** _____ / _____ / _____
*mm dd yyyy* *mm dd yyyy*

**Direct supervisor:** _____ _____
*Name* *Phone*

**Type of injury/illness (eg. Sprain, laceration, break, etc.):** _____

**Part of body affected:** _____ **Left side:** ___ **Right side:** ___ **Both Sides:** ___

**Did injury/illness exposure occur on state property?** Yes___ No___ **Did it result in lost time:** Yes ___ No___

**Location of accident/illness exposure:** _____
*Street* *City* *State*

**List all: equipment, materials, and chemicals being used when the accident/illness or exposure occurred.**

_____

_____

**Describe specific activity you were engaged in when the accident/illness exposure occurred.**

_____

_____

**Describe your assignment at the time the accident/illness exposure occurred.**

_____

_____

**How did the injury/illness or exposure occur? Describe the sequence of events and objects or substances that directly injured the employee or made the employee ill.**

_____

_____

_____

_____

**Was safety equipment provided?** Yes ___ No ___ **Was safety equipment being used?** Yes ___ No ___

**Initial Treatment:** None ___ (Notify Human Resources immediately if you receive medical treatment sometime in the future)
Minor by employer ___ Minor by clinic/hospital ___ Emergency care ___
Hospitalized 24 hours: Yes ___ No ___ Future major medical/lost time anticipated: Yes ___ No ___

**Health care provider (Treating Physician):** _____
*Name*

**Address of health care provider:** _____
*Street* *City* *State* *Zip Code*

**Name of hospital (if used):** _____

**Address of hospital (if used):** _____
*Street* *City* *State* *Zip Code*

**Witnesses:** _____ _____
*Name* *Phone Number*

**Supervisor's comments:** _____

_____

_____

_____ _____
**Employee Signature or Designee (person completing form)** **Date**

Complete this form as soon as possible after the accident or onset of the illness and send or deliver it to the Department's Human Resource Office.

- Physical Address: 1594 West North Temple, Suite 316, Salt Lake City, Utah
- Mailing Address: Department of Natural Resources, Human Resource Office, P.O. Box 145610, Salt Lake City UT 84114
- FAX: 801-538-7219
- E-mail: nrhractions@utah.gov

Call the Human Resource Office at 801-538-7318 if you have questions or need assistance in completing this form.